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Keywords: Institutional
change, quality registers,
public governance, path
dependence, time

Abstract

When explaining social development and changes in public administration, institutional change is a typical focus. Institutional analysis can combine the analyses of changes on the basis of formal legal and informal arrangements; it commonly shows that institutions lead to inertia where changes over time are concerned. Political aims are a guide to how organizations are designed and governed. When goals and earlier decisions clearly guide change, path dependence is a fundamental concept when explaining change. However, this analysis shows how and when quality registers appeared as an answer to changes in institutional arrangements in Swedish public healthcare. Through three phases, cumulative processes have been visible and the processes have been followed by an improved and increased usage of quality registers and other quality systems. This analysis shows that institutional development can be path-dependent in relation to methods and means. Despite changing goals over time, quality registers as a policy tool have been path-dependent and stayed firm. Thus, it is important to see also organisational methods as a development path that can be used to implement even new policy aims.

Introduction

Healthcare in Sweden has in recent decades struggled to implement different kinds of methods for handling quality issues. This article addresses the development of quality registers from an institutional perspective and how these registers, as a policy tool, have survived and been institutionalized in spite of changing policy aims. Quality registers are a unique asset in Swedish healthcare and should be understood as prospective observation studies. The registers mainly aim to provide activity analyses and continuous monitoring of clinical work. Their strength is generalisation and the ability to statistically analyse unusual and serious complications (Vårdanalys, 2013).

The medical profession in Sweden since the 1970s has developed quality registers; especially in the last 10-15 years there has been a rapid growth in the number of registers. Several of the registers are now national in scope with a high degree of decentralized responsibility and used in daily practice as well as for political management (SKL, 2010).

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There are currently 79 different quality registers operational in Sweden with financial support from the public health authority and the government, which is by far the most anywhere in the world (SKL, 2014, web). There are also 25 quality register candidates in the process of development with financial support. However, not only Sweden has quality registers. There is a growing interest in national quality registers outside Sweden; notably the other Nordic countries have developed some quality registers. In orthopaedics, for example, we see quality registers also in Norway and Denmark, in collaboration with Sweden, for some years now (Havelin et al, 2009; 2011).

Quality registers have become a policy tool for management healthcare and, over time, they have developed and addressed different policy aims. In this study, we have followed their development and growth and can explain the development trajectory of quality registers in Sweden through three phases. Initially, they were formed to support professionalism and quality development. Later, more administrative and economic aspects were added to the system and, recently, they have been more transparent and thereby a tool for increased patient involvement and political debate.

Political objectives normally govern the institutional arrangements; they thereby provide a model for the path that the change will follow. Methods and means of implementation are expected to vary to achieve the goal (Pierson, 2004). However, this case shows that the objective for what is governed has developed over time, but the policy tool has been stable through the sustainable use of quality registers within the Swedish healthcare system. The contribution to this theoretical outlook lies in our argumentation that it is possible that these methods and means also can be path-dependent and that, over time, different objectives can be inserted into quality measurement as a policy tool.

Theoretically, this responds to the concept of “layering” (Streeck & Thelen 2005, Mahoney & Thelen 2010), which means that institutional change emerges through new rules and routines that are added, layer by layer, on top of already existing institutions. Even if such influential veto-making entities as the medical profession can defend existing institutions, they cannot necessarily prevent new objectives, rules and procedures from being added. Quality registers were initially built up as a method for quality measurement, with a particular technique and with an objective that was of key significance at the time. Over time, they have subsequently developed multiple objectives.

Accordingly, the overarching purpose of this article is to show how a policy tool (i.e. quality registers) can survive and be institutionalized in spite of changing policy aims. We do this by analyzing the development of quality registers in Swedish public healthcare from an institutional perspective. This is expressed in two research questions: what characterizes the development trajectory of quality registers; what are the paths followed in this development? In addition, what can be learned from this particular case?

This article describes the development of quality registers based on document analysis and interviews with key actors. The growth of the quality registers is explained in three historical phases; starting in the seventies when they grew

out of the medical profession for medical follow-ups. Secondly, how they were inserted into emerging management models, and ultimately how they currently contribute to the contemporary shift towards increased transparency and citizen participation. Finally, in light of this case study, we analyse and discuss whether, and if so how, these means and methods can create path dependence in institutional change, and what more general implications could be drawn from such a conclusion. First we shall introduce our theoretical perspective, methods and analytical approach.

Institutions and path dependence

One way of explaining the development of public administration is to look at the changes in the institutional context (Mahoney & Thelen, 2010). Fundamental values are shaped by the institution's normative functions and then made more concrete in its regulated role (Scott, 2008). A properly functioning institution acts as guide in both formal and informal fields, and as a cognitive tool to create an understanding of rules and standards.

However, institutions are resistant to flexibility; because of this they have the power to create path dependence – in other words, they limit change through the fact that development has a tendency to follow the same path (Bladh 2008; Pierson, 2000; Pierre, 1993; North, 1990). In public health administration, political values and norms are wrapped up in institutional arrangements, which are often path-dependent.

The institutional framing of policy change

As stated, healthcare policy is constrained by institutional arrangements, such as legal, cultural and cognitive activities. According to Scott (2008), these institutional arrangements can be expressed through three pillars, which constitute the foundation of institutions. Firstly, there are legal and constitutional arrangements. Secondly, informal cultural norms, structures and principles developed against the background of the formal; and finally, institutions that have a cognitive function through creating structures for how we perceive the context in society and thus how we talk and think about them. Since institutions have normative, regulatory and cognitive functions, institutional change can also be observed in the same manner in all these respects.

In the words of North (1990), institutions are the rules of the game, humanly devised constraints that shape human interaction, which are not outside human control. Accordingly, institutions are collective choices that are the outcome of a political process and healthcare institutions depend on the political institutions. In this perspective, an institution is a collectively accepted system of rules, norms and cognitive perceptions in the form of a code of conduct (Searle, 2005). A collective intentionality is needed and a cooperative behaviour. Medical professions implement a health policy decision when measuring quality, as if engaged in a collective intentionality. Individual action is part of the collective behaviour and confirms the institutionalisation. Their major effect will be

through incentives and have consequences on healthcare development (Acemoglu & Robinson, 2010; Commander & Nikoloski, 2011). This can be summarized as political institutions having an impact on healthcare institutions that, in turn, affect healthcare performance.

A temporal perspective on institutional change

To study institutional change over longer periods of time is essential to get away from the institutional snapshots dominating social sciences. The current discussion on institutions and development is a poor way of understanding the changes in institutions themselves (Chang, 2011). To understand change, one must understand the process as a whole over time, and not just disjointed parts of it (Pollitt, 2008; Lundquist, 2006; Pierson, 2004; Jervis, 2000; Hägerstrand, 1985; 1976). Consequently, it is the overall picture of change that calls attention to and illustrates change. The fact that time is constantly moving forwards is normally taken for granted. It is therefore embedded in the web of structures and activities that comprise all contexts (Hägerstrand, 2009).

Processes are a progression of events over time. Events that have occurred contribute to the shaping of what choices are possible later (North, 1990; Hägerstrand, 1985). In other words, the decisions taken at one point in time can limit the space for action and the range of possible choices later. This means that certain principles are built-in and shape what can be done. Pierson (2004) stresses that such institutionalization processes are a result of continuous "positive feedback", i.e. choices made earlier are more important than those made later, and that subsequent events may have less meaning than they would have had if another path had been chosen.

Path dependence as a framework for Institutional Development

A path dependent sequence of changes is linked to decisions taken in the past and omnipresent institutions. Since strong structures dominate, the development is likely to be incremental (Wilsford, 1994). Many arguments for path dependence assume that competing social players fight for the same political space on the agenda and in decision-making (Kingdon, 2011; Pierson, 2004). To understand institutional change we need to focus on identifying the timing of institutional choices and the implications on the processes (Pierson, 2000).

Hägerstrand (1985) shows how processes of change are continually structured by constraints from institutional arrangements and past processes. For political contexts, it could be predetermined parliamentary terms and fiscal years (Wihlborg, 2000). Therefore, the mechanisms that generate the restrictions need to be identified, which may be a source of insight into what determines institutional change. Important influences on choices might exist only for a limited time and cannot be easily identified in an "on-the-spot" study focusing on the choice of particular players. It is also necessary to have an understanding of the resistance to such a change. A theory of institutional change therefore needs to contain the aspect of institutional resistance.

The state has long been considered to have constitutional primacy in forming the decisions that shape institutional arrangements. However, Sørensen, & Torfing (2007) see that the role of the state is to act as a “facilitator” rather than to work through “command and control”. The ambition is then rather to avoid institutional resistance in order to enable change to take place. The institutional capacity of the state will change and, over time, more decisions should appear that offer more space for action, rather than those that lock in to path dependence. In this case, players who introduce new procedures and objectives that involve refining or correcting an already existing method or tool (Mahoney & Thelen, 2010; Streeck & Thelen, 2005) can set changes in motion. By having these new rules and objectives, which have followed previous institutional norms, “layered over” they will not directly undermine the existing institution. Entities of change can thus avoid a major backlash from those who want to preserve the status quo.

Path dependence is often seen as both a self-reinforcing process of development and as a result, or a stable outcome with unique properties, which will be a hindering factor in institutional change (Vergne and Durand, 2010). Alternative paths are deselected when a self-reinforcing mechanism occurs and that in turn causes a lock-in effect. There are some character traits that illustrate self-reinforcing processes (Pierson, 2004). At the starting point there are a multitude of possible outcomes. Small events can, at the right time, result in large and far-reaching consequences. When an event occurs in the sequence can be crucial for further development. Once a development process has become established, the self-reinforcing processes contribute to an equilibrium situation that is resistant to change.

A common conception is that the early steps of the process are strengthened over time while the later steps are weakened. In analysis, it is therefore important to specify the mechanisms that reinforce a particular development path (Mahoney & Thelen, 2010). Without this, the argument for path dependence is watered down to be merely a description of stable conditions.

In sum, the political institutional frame sets the scene and restrains the implementation of policies, in this case the healthcare performance. Over time, new institutional layers change the preconditions giving the individuals different spaces for action. A crucial role is played by what resources are available relative to other entities. Those who can gather advantageous resources early on can produce major consequences for subsequent developments. Institutional choice leads to path dependence, which locks in processes towards certain types of development, usually in order to strive toward a goal which had previously been the focus.

However, in this article we argue that institutional development can be path-dependent in relation to methods and means. Despite changing goals over time, quality registers as a policy tool has been path-dependent and stayed firm. To illustrate the theoretical arguments and to explain a historically important case we have chosen a case study method.

Methodology of the Case Study

The study makes use of a disciplined configurative case study design to comprehend the institutional layer that has a prompt impact on the historical quality development in healthcare services (Roberts, 1996; Lijphart, 1971). This is a case in which the emergence of new institutional layers is focused on the basis of three particular moments in time. The case also impugns the established theoretical perceptions of path dependence in relation to political goals and highlights the need for a theoretical view that also considers path dependence in relation to methods and means.

This case study, based on a variety of documents, such as laws, evaluation reports, medical journals, social science studies, and also interviews, focuses on the major features of development in order to reveal procedural changes on a structural level. The tracing of the process through documents is based on the homepages of the Swedish Government, the National Board of Health and Welfare (NBHW), the Swedish Association of Local Authorities and Regions (SALAR) and the homepage of quality registers. The analysed public documents were selected by following the process backwards, and in this way the development of quality registers in healthcare has been followed back from what they eventually became. However, not only did these public documents touch on the quality registers; they placed them in a wider context of public health reforms.

The interviewees were chosen strategically to create a comprehensible and a systematic picture of the development of the quality registers. These included healthcare professionals chosen on the premise that they could provide insights into quality registers. Since the informants presented a coherent picture of the overall development, we faced saturation in the interview material at an early stage. Of course, many physicians can provide detailed information about the quality registers as such, but that is not the focus of this study. Rather, it is the progress of the quality registers as a policy tool that is of interest.

The interviews were semi-structured and followed the central theme that had previously been identified through the study of documents. The informants were given questions about two main themes. Firstly, they were asked about risks and opportunities in the developments of the quality registers. Secondly, they were asked to tell their own story about their involvement in the processes of quality registers. The interviews were then transcribed, and used in other analyses with different focus than this article (Örnerheim, 2011). As we traced the progress of quality registers, we also noticed that the institutional settings differed every time the development took a leap forward. Here, however, we focus on path dependence in institutional change and how new goals, rules and routines were added to the original tool. This pattern is developed in the following.

Quality registers in healthcare, a policy tool as an institutional arrangement on a new path

The quality registers should be seen as part of the quality movement in the private and the public sectors, which started in the 1970s. Contrary to the idea of

quality assurance, which has been introduced by public officials in the healthcare sector, the quality registers have been developed by the medical profession (Garpenby & Carlsson, 1994; Interview B, E, and G). Quality registers are a type of tracking system used to systematically improve care and can be considered a kind of policy tool because, in the way they are organised and how the work is structured, they provide opportunities for monitoring and control (Elg et al, 2011).

Three issues are equally important for quality registers and for the healthcare system as a whole: Who has been treated? What has been treated? How did it go? Registers are thus a patient-focused system for monitoring and developing treatment results that contain data linked to an individual on the problem/diagnosis, the actions taken and results (Prop. 2007/08: 126, s. 176-180; SKL, 2014, web). Quality registers can therefore be regarded as a complete system of knowledge that provides the opportunity to measure a number of dimensions – medical quality, patient-perceived quality, process quality etc. – and that can be used actively at all levels for continued learning, improvement, management and control of all healthcare activities (Interview B, C).

The purpose is to measure the quality of care in several dimensions and from different professions' point of view and it is the patients' path through healthcare that is supposed to be the guiding star when you measure and not the organisational or professional boundaries.
Interview C (auth. trans.)

Overall, quality registers should not only be seen as a database, but should be seen as a support structure for quality and knowledge management in healthcare. There is no binding legislation in this area. However, Chapter 7 of the Swedish Patient Data Act (SFS 2008:355) governs the right to manage data in registers for monitoring, evaluation and quality assurance in healthcare and research. The functionality of quality registers is thus highlighted through government agencies being given the ability to manage the data rather than the requirement to do so.

The registers are used to monitor performance over time in continual improvement work at clinics and health centres for the purpose of providing early warnings if something is not right. It is only by carrying out measurements over longer periods that changes of a more fundamental nature emerge (Interview B and C). They can also be used for comparisons between clinics and regions as well as be used to verify adherence to national guidelines or objectives and serve as support in daily work. The registers also provide the opportunity to draw conclusions that are only possible with a large amount of material. This also gives a chance to compile informational material for patients. Finally, the registers can, naturally, be used in clinical research. Simply put, it may be said that the main task of a registry is to create support and consensus on variables, analyse collected data and feed this back (Interview B, C).

The registers undergo an annual review and assessment in order to be approved and have the opportunity to obtain the support of the Decision Body for National Quality Registers.¹ The Decision Body works according to a number of principles in the development of quality registers (Interview B, C).

The principle has to be, this is the profession's register, and they have to take responsibility for their own results. They must learn and build their own systems and nothing good come out of it if we build their systems. A clear separation of roles as a principle. Interview B (auth. trans.)

A basic principle is that the registry has been started and is run by the profession, where participation is voluntary. Another principle is not to seek a patent solution for all registers, but have them grow and develop themselves - organically. A further principle is that the professional groups concerned themselves need to agree on what should be measured and what constitutes good care in each area. An important principle in this context is that the results are not designed to be used for supervision but rather for learning and improvement that will benefit patients. A final important principle is that if there are specialist associations then the registers have to have the support of those associations. The registers are also expected to report their results openly, accessibly and be adapted for the medical professions, the public and healthcare management organization.

In recent years, the demands for compatibility with the regions' various IT-based medical records have also increased. Running a register is thus far-reaching work and requires different skills such as registry skills, medical skills, improvement capability, statistical skills, legal skills, IT skills, teaching skills, negotiation skills, gender skills, and knowledge of health-related quality of life and patient-reported measures.

In light of this, we have identified three institutional layers dominated by different policy aims, by which quality registers as a policy tool have survived and evolved. Firstly, the politicization and professionalization of healthcare, then the influences of management discourse in healthcare and, finally, increased requirements for transparency and political efforts to improve healthcare.

The politicization of healthcare and the emergence of quality registers

During the dominance of the Social Democratic party from the end of the Second World War up until the mid-1970s, the overall policy objective was to achieve equality, security and accessibility in various policy areas, and healthcare was no exception (Immergut, 1992; SOU 1948:14). Reforms, inspired by the British NHS, led to a complete reorganization of the Swedish healthcare system. Public services should be of such high quality that there would be no interest in competition from private alternatives (Larsson et al, 2012; Rothstein, 2010; Blomqvist, 2004). The reforms meant, among other things, that opportunities for hospital doctors to have private surgeries disappeared and were replaced

by a new salary system with a monthly salary and regulated working hours (Carder & Klingberg, 1980). During this period, the professional dominance and its own control logic based on biomedical knowledge/training was challenged by a political logic based on normative ideals of equality and accessibility (Scott, 2000; Heidenheimer, 1980).

Like so many other countries in early 70s, Sweden was affected by the global recession and the oil crises of 1973 and 1979, which resulted in higher unemployment, lower growth, and higher inflation and therefore lower revenues for the state. The County Councils were formally governed at that time by multi-year plans (SOU 1984:39). The governing ideals of the time were based on planning and control, where resources were allocated on the basis of the planned needs of the various County Councils. Combined with a not-too-restrictive financial governance this led to large budget deficits in the public sector, which created a need for streamlining. The recessions did not allow for further expansion; instead, the regions needed to finance healthcare from within the municipal tax revenues, and the County Councils themselves needed to become financially viable. This was followed by cost-control measures due a growing need to measure effectiveness and profitability (Ternblad, 1992).

Whilst this development was taking place, the medical profession continued to have a great influence over management and planning. The interests of the state and the County Councils in production control coincided in this respect with the medical profession's interest in the tracking system. This did not only provide a better environment for the development of the medical sector, but also meant improved conditions for physicians (Garpenby, 1996).

During the 1970s, various types of registers developed within the medical professions with the aim of monitoring treatment outcomes. The early registers were entirely paper-based and developed in local clinics by individual physicians without any special budget for their development (Interviews B, E and G). The most famous is probably the Swedish Knee Arthroplasty Register, developed at Lund University Hospital for the purpose of systematic follow-up of knee surgery, a medical field that was undergoing rapid development (Robertson et al, 2000). There are also other local examples of registers that developed at this time.

Dialysis treatment was another area that was under heavy development and the uremic syndrome registry was developed at Linköping University Hospital in order to monitor patients receiving dialysis (Interviews E, G). Budget negotiations were viewed as a factor that held things up, and they somehow needed to be dealt with in order to develop the clinic and – in this case – open an additional clinic. This approach is also highlighted in an article by Robertson et al, (2000:17) on the Swedish Knee Register:

Purchasers of medical treatment, authorities or clients are more willing to give financial support when effects of previous financing can be shown, the results of the treatment can be documented, improved in quality with time be demonstrated and future trends can be predicted. The register has provided this information, which helps the

orthopaedic profession in the struggle for meagre medical resources. Further, this will benefit not only surgeons, but orthopaedics as a whole.

Thus, through politicising the healthcare system, new institutional layers were created that influenced the emergence and development of national quality registers. Ultimately, through the expansion of a public healthcare system, there arose a need for efficiency and cost control. This drove the development of measurement systems and quality control, where the various interests and goals of the County Councils and the medical profession intertwined in mutual development.

The Quality of Organization and Medicine, NPM enters the field of healthcare

The management development that inspired the public sector during most of the 1990s often goes under the collective name of NPM - New Public Management (Hood, 1995; 1991). In the Swedish healthcare similar developments have been analysed (Larsson et al, 2012; Christensen & Lægheid, 2007; Mörth & Sahlin, 2006), as with other parts of the public sector. The interesting question in this context is, naturally, how did this development affect the quality registers?

Various forms of control systems drawn from the private sphere, such as financial performance, performance management, purchasing management, customer choice and customer oriented process orientation, have been planted in public healthcare (Berlin & Kastberg, 2011). It has also become increasingly common to use the term customer rather than patient even in the healthcare system (Nordgren, 2003). This development was driven by a widespread and growing dissatisfaction with an inefficient healthcare system with poor accessibility. Management ideas can also be seen in the reform proposals during this period (Garpenby, 1995), especially in the Governmental Bill on Family Doctors put forward in 1992 and in 1978 by the right-wing governments (SOU 1978:74; Ds 1992:41).

In the 1980s and 1990s, there was an economic pressure and a wide gap of trust about accessibility, just like today. Privatisation emerged as an answer to the problems in the public sector. There is a fear to forget the content of care in the dogmatic economic principles, so you start working with quality issues. Interview D (auth. trans.)

The medical profession is rooted in the biomedical knowledge model that traditionally serves as a basis for medical training. The profession takes its primary knowledge from education; one of its main goals is to create new knowledge. This professional knowledge is characterized by subject knowledge, personal skills, values and ethics. It is also on this particular development pathway that quality registers were further refined (Garpenby, 1999; Interview A, B and D).

In the early 1990s, both the former Federation of County Councils (FCC) and the NBHW became aware of the registers and of their potential (Interview B). Between 1990 and 1994 the number of registers rose from 7 to 16, with the medical profession still uninfluenced by other entities in their developing of these registers. Market-based management principles at the time influenced the overall quality development of methods for measuring healthcare quality. These influences eventually led to collaboration between the FCC, the NBHW, and representatives from the medical profession, which established the “Decision Body of National Quality Registers” in 1995. The Dagmar Funds (Government Funding for Rehabilitation Projects) contributed to the financing of the registers. The registers then became part of a policy network, which also included public bodies; the registers were no longer solely a matter for the medical profession (Garpenby, 1999).

In practice, however, registers were still tools for the profession, but with the help of new structures and funding opportunities more registers developed. National quality registers began their institutional development and the number of registers increased rapidly (Garpenby, 1999; Garpenby & Carlsson, 1994). By 1998, the number of registers had grown to 45.

The growing development and connection of the registers with national authorities meant that they were no longer just an issue for the medical profession. New entities entered into the development of registers; more administrative levels were involved and redesigned in order to meet this development. Management as an institutional layer was thus a prerequisite for the growth of quality registers taking a developmental leap. The methods relating to quality registers were thus developed and strengthened by being institutionally coordinated with, and being incorporated into, new targets based on management ideas. By acting as a measurement tool in the management of healthcare, the goal was to determine whether the healthcare actually became better – even on an administrative level.

Once management as an institutional layer is established, it has in turn facilitated the development of a new layer of transparency, based on principles of openness, competition and quality metrics, which have received entirely new opportunities with technological developments.

Quality registers in a transparent healthcare system

Today, the Swedish healthcare system is characterized by an increasing number of initiatives, designed to make healthcare more transparent for citizens in the roles of patients and taxpayers. Various quality assurance systems, ranking systems and patient choices have been introduced in the healthcare system. This – together with increased technological capabilities – leads to hopes for better transparency in quality reporting in order to facilitate patient choice (Hood & Heald, 2006). Over the past 10-15 years, transparency within the healthcare sector has been inserted as an institutional layer, which the political, administrative and professional sectors have all needed to adhere to (Örnerheim, 2011; Andersen, 2007; Blomgren & Sahlin, 2007; Levay & Waks, 2006). This tenden-

cy towards transparency is also accompanied by traditional democratic ideals whereby citizens are to have insight into public activities.

Different entities – primarily health authorities, professional associations, patient associations, private healthcare companies, trans-national organizations and networks – have, for varying reasons, called for greater transparency. The most recurrent argument is that it benefits the patient, but transparency is also believed to contribute to streamlining and development and to boost the confidence of both patients and the public (Blomgren & Sahlin, 2007). This trend became clear in the early 2000s and is justified in part by the increased availability of information via the Internet and other information technologies.

The quality registers that are high performing in feedback and development on a monthly basis are the most successful. (...) The leadership is the primary impetus for this. Spreading to the employees on how to think about improvement and quality. Interview F (auth. trans.)

A critical event was when RIKS-HIA – the Swedish Register of Information and Knowledge about Swedish Heart Intensive Care Admissions – was placed in the SAS database² shortly before the new millennium (Interview B and F). This led to the earlier compiled work of the registry being greatly streamlined; at the same time it created more opportunities for analysis, processing, development and clearer presentation of results (Interview F). RIKS-HIA has since published results at the regional and hospital levels (Bohlin & Sager, 2011). At that time, there were extensive discussions about IT support. In parallel with this, the National Diabetes Register (NDR) independently developed an equivalent system. Thus, there were two IT breakthroughs around the same time due to proactive register holders; more registers later followed in their footsteps. There have since been more and better registers with data that are more relevant, more used, and have a wider coverage (Interview B, C and G).

Corresponding to this development, there has been a public debate, which has been based on such aspects as problems of accessibility and how open the medical profession should be with their results in order to facilitate patient choice (Interview B, F and G). The debate has focused primarily on the intersection between personal integrity and open government. An additional feature that strengthens how quality registers are used in order to gain transparency is the development of “Open Comparisons”. The first Open Comparisons were presented in 2006 and, as the name implies, are an open comparison based on information from several different quality registers within healthcare and the health data register of the NBHW. (SKL, 2012, web; Socialstyrelsen, 2012, web).

This (open comparisons) is another path. There are several paths intertwined. On the side, there has been a debate on whether the doctors should agree on opening their results to the public. Those two paths crosses here. Interview B (auth. trans.)

Open Comparisons is not primarily intended to support patient choice, but rather to provide a basis for the political debate on healthcare and to improve the conditions for accountability and encourage Sweden's County Councils to improve and to learn. They also act as knowledge support for the regional monitoring and control in each county council. As a policy tool Open Comparisons can be considered a soft instrument, since it lacks legal sanctions and instead follows the logic that the regulated body risks losing face if the services it provides are not good enough (Blomgren & Waks, 2010; Öppna jämförelser, 2010). Quality registers have not been the prerequisites for Open Comparisons, although much of the information that is used in Open Comparisons can be found there. A vital discussion today concerns how data from the registers should be presented in the best way for the public and other groups (Interview B).

Developments towards increased transparency have appeared in various channels and at different levels, and new entities have entered the arena during the early years of this century. Two main approaches can be discerned in particular; both a development of quality registers in themselves and a societal trend towards transparency, which have intertwined in mutual development. In this process, we can see the entrance of new entities, with the consequence that behaviours and attributes gain new meanings.

When different development channels intertwine, organizations are reshaped and they interact in new ways; boundaries are shifted or transformed. Even though transparency and reporting of results has become a task for national quality registers, it is still under debate and some key objections are usually made (Interview B, C, E, and G). The results can be difficult to interpret and understood for those not familiar with the methodology. There may be a risk that healthcare organizations only accept patients or clients who are likely to yield good measurement results. Another hazard commonly cited is that measurement, analysis and verification become the most important factor and the professional role is eroded. Therefore, it is a question of risks arising from processes and the strategic behaviour of staff contributing to unwanted effects.

In summary, the registers have evolved from being a tool primarily for the medical profession to also include governance, development and a learning instrument for the responsible authority and other agencies. The stage of development we see today is one with more openness and greater opportunities, even for the public, to share results and gain knowledge generated by the registers.

Conclusions: Path dependence on new roads

The argument in this article is that when we visualize changes over time, we can also see that what primarily is a medium or method can be institutionalized in order to realize different values in the democratic administration. So, what characterizes the development trajectory of quality registers?

The quality registers have been developed over time, and the techniques and methods that are associated with national quality registers can be seen as a pro-

cess of institutional development. Historically, the dominant institutional layer within healthcare is based on medical quality, evidence and best practices, which are determined by the medical profession through its expertise in medical science and technology.

The main conclusion of this analysis is that the tool – Quality Registers in Healthcare – was more path-dependent than the new objectives that characterized publicly funded Swedish healthcare over the forty years being studied. The tool can be said to have been institutionalized so strongly that additional policy objectives have been incorporated into the tool, through a gradual evolution over time. Quality registers have grown – both in number and in scope – over this period and the tool has developed, but the basic idea to record and measure outcomes in order to improve the quality of healthcare has remained constant.

Through this analysis we can identify four dominant principles or rules for the development of quality registers, according to the logic of which the Decision Body for National Quality Registers work can clearly be traced. Firstly, the register must be built and operated by the medical profession and, secondly, it must be grounded in specialist associations. Thirdly, the results should not be used for supervision, but for learning and improvement that will benefit patients. Finally, the professional medical groups themselves agree on what to measure and what is good care. This shows that the dominant role of the medical profession constitutes the critical grounding for this development.

In relation to this grounding in the medical profession, the politicization of healthcare has challenged this logic through the establishment of an institutional layer based on ideals of equality and accessibility and later also cost containment. Meanwhile, it is apparent that it was in the competition between these institutional layers that the registers came to fruition.

However, criticism towards the public sector and the strained economic situation also created a need for financial management and quality reviews. With inspiration from the private sector, a new institutional layer was built up based on management and quality assurance. This contributed to the interest in quality registers and attracted the attention of more players mainly at national level. An ever-closer link was created between the different groups of players that contributed to quality registers being given the opportunity to access state funding and hence achieve better development. Here another principle arose, namely not to search for an overall solution for all registers but rather to let each registry emerge through evolution as a controlling principle.

Later, the traditional democratic ideal of citizens having insights into public agencies, combined with a general trend towards greater openness, had established an institutional layer grounded in transparency as a political ideal. This could be said to be a strengthening of the ideals that form the basis of NPM, namely competition and choice. Without transparency and information about quality, it is not possible to make choices and create competition. Another principle can be derived from this, namely that the register is expected to report its findings in a way that is transparent, accessible and adapted to the medical professions, healthcare management organizations and the public.

Through this process, a mutual understanding concerning quality registers has emerged. The principles stated by the Decision Body of the National Quality Registers are essential for the development of quality registers in that they show an adaptation to institutional layers. We would therefore argue that the case study is characterized by path dependence in *how* things are done, rather than *what* and *why* management does things. Then, what can be learned from the particular case?

In theory, institutionalized arrangements follow a goal, or value, but may use different means to achieve this goal. Quality registers have grown and developed through an incremental process in which the targets that initially existed institutionalised a tool, which then become a guide for how future political objectives were to be implemented. By layering, and new logics, the motives and goals for publicly funded healthcare have been annexed to this method's way of working and organisational model. Quality registers have become a policy tool in the form of collective assignment of function, i.e. a united acceptance of the community or context in which the quality registers have a certain status.

Against this background, we want to put forward three conclusions. Firstly, the case study teaches us that path dependence can be method-contingent rather than goal-focused. Secondly, we see two main reasons for this: the lack of flexibility of organizations and the cost of making changes, which should be able to point to some generalisations. Finally, it shows the point of making changes visible over time and how decisions made at one time shape future action and possible decisions.

Quality registers appear as institutionalized in all three pillars. Although there was no law requiring the administrative authorities to run quality registers, a section of the law was developed that provided opportunities for such entities. Thus, there is a formal pillar in the institutionalization. The informal and normative pillars of institutionalization were pointed out as very clear and important among the interviewees; monitoring, evaluating and especially comparing results over time with one's own and other County Councils was important for the organizations. In this way, we can also see a cognitive pillar in the institutional arrangement: the development of knowledge is built and shaped by the quality registers. This is particularly evident on the websites where both SALAR and the NBHW describe their work with quality registers.

Although our case study is not primarily focused on the reasons why the quality registers emerged as an institutionalised policy tool, we see two possible explanations. It is evident that different goals can be embedded and added as layers in these systems, which appear to be resistant to change at the same time as they are growing. Path dependence is often seen as something negative for a modern organization, as stabilizing and conserving. But we would argue that this case study suggests the opposite, namely a creative interpretation of how the new targets can be inserted into the existing methods and approaches.

A classical management theory would be that there are high changeover costs in organizations and therefore it is cheaper and easier to do as you did before. In particular, the second phase of NPM ought to further justify keeping

the changeover costs as low as possible. Therefore, quality registers could survive not one but two changes in the objectives of the operations. This suggests that organizations are sluggish or resistant to change; they have things to gain by maintaining their path dependence. The question of whether the size and the fundamental political control – that is, the five-year plans of the 1970s – made the County Councils and healthcare in general resistant to change, and justified the strong path dependence identified should, however, be an issue for future analyses. There are also clear motives for integrating new technologies into existing management models, which is in line with theories of how new technologies, are taken up by management organizations.

Thus, there is potential for conceptualizing management development and organization in new ways, if longer time perspectives are used and time is made an explanatory factor. As decisions build on each other and form the contexts for future decisions, available resources and constraints for management can be revealed. Unexpected methods and tools may possibly be seen as the ones to create new paths for organisational development.

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Notes

¹ The Decision Body for National Quality Registers is made up of representatives from SALAR, NBHW and also the medical profession and Register-Holders

² Statistical Analysis System, computer program for data preparation, statistical analysis and reporting